Reticulocyte Count Template

Patient Information Age: _____ Gender: _____ Date of Birth: ____/___[DD/MM/YYYY] Patient ID: Contact Information: _____ Insurance Provider (if applicable): _____ **Physician Information** Referring Physician's Name: _____ Specialty: Contact Information: _____ Physician's Notes/Requests: **Specimen Information** Collection Date: ____/____ [DD/MM/YYYY] Collection Time: _____ [HH:MM] Specimen Type (e.g., Blood, Bone Marrow): _____ Collection Method (e.g., Venipuncture, Capillary): _____ Patient Conditions/Medications that may affect count: **Test Requested**

Other Hematology Tests (specify): _____

Results

□ Reticulocyte Count

Measurement	Result	Reference Range
Reticulocyte Count (%)		
Total RBC Count		

Hematocrit (%) Hemoglobin (g/dL) Additional Measurements Interpretation and Comments [Add any significant findings, interpretations, or recommendations for further testing here. Include consideration of age, gender, and clinical context.] Lab Certification and Technician/Pathologist Information Lab Certification Number: Technician/Pathologist Name: Signature: Date: /					
Interpretation and Comments [Add any significant findings, interpretations, or recommendations for further testing here. Include consideration of age, gender, and clinical context.] Lab Certification and Technician/Pathologist Information Lab Certification Number: Technician/Pathologist Name: Signature: Date: J. [DD/MM/YYYY] Time of Report Completion: [HH:MM] Additional Notes [Any additional observations, comments, or contextual information relevant to the test or results.] Patient Consent for Testing (if applicable): I consent to the processing of my specimen for the purpose of medical diagnosis. Patient Signature: ———————————————————————————————————	Hematocrit (%)				
Interpretation and Comments [Add any significant findings, interpretations, or recommendations for further testing here. Include consideration of age, gender, and clinical context.] Lab Certification and Technician/Pathologist Information Lab Certification Number:	Hemoglobin (g/dL)				
[Add any significant findings, interpretations, or recommendations for further testing here. Include consideration of age, gender, and clinical context.] Lab Certification and Technician/Pathologist Information Lab Certification Number: Technician/Pathologist Name: Signature: Date: [DD/MM/YYYY] Time of Report Completion: [HH:MM] Additional Notes [Any additional observations, comments, or contextual information relevant to the test or results.]	Additional Measurements				
Lab Certification Number:	[Add any significant findings, ir	nterpretations, or recommendat	tions for further testing here.		
Technician/Pathologist Name:	Lab Certification and Technician/Pathologist Information				
Signature: Date:/[DD/MM/YYYY] Time of Report Completion: [HH:MM] Additional Notes [Any additional observations, comments, or contextual information relevant to the test or results.] Patient Consent for Testing (if applicable): I consent to the processing of my specimen for the purpose of medical diagnosis. Patient Signature:	Lab Certification Number:				
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שמופיושוואו/שטן שמופי	I consent to the processing of n	ny specimen for the purpose of	f medical diagnosis.		